



Department of Veterans Affairs

## APPLICATION FOR CHAMPVA BENEFITS

CHAMPVA CENTER

PO BOX 65023

DENVER CO 80206-5023

800-733-8387

**BEFORE COMPLETING, CHECK ELIGIBILITY CRITERIA ON BACK****I - SPONSOR INFORMATION**

|  |   |  |                           |  |                                  |
|--|---|--|---------------------------|--|----------------------------------|
| 1. VETERAN'S NAME (Last, first, middle initial)  |   | 2. TELEPHONE NUMBER<br>(Include Area Code)   | 3. SOCIAL SECURITY NUMBER | 4. DATE OF BIRTH<br>(Month, day, year) | 5. VA FILE NUMBER (Claim number) |
| 6. IS VETERAN A MILITARY RETIREE<br><input type="checkbox"/> YES <input type="checkbox"/> NO | 7A. IS VETERAN DECEASED<br><input type="checkbox"/> YES <input type="checkbox"/> NO | 7B. DID VETERAN DIE WHILE ON<br>ACTIVE MILITARY DUTY<br><input type="checkbox"/> YES <input type="checkbox"/> NO |                           | 7C. DATE OF DEATH (if deceased)        |                                  |
| 8. LOCATION OF VA REGIONAL OFFICE<br>(City and State)  |   |  |                           |  |                                  |

**II - APPLICANT INFORMATION**

| NAME<br>(Last, first, middle) | ADDRESS<br>(Street, City, State and ZIP) | SOCIAL SECURITY NO. | TELEPHONE NO.<br>(Include Area Code) | DATE OF<br>BIRTH<br>(mo/day/yr) | RELATIONSHIP<br>TO VETERAN | FULL-TIME<br>STUDENT<br>(If yes, provide<br>certification of<br>school enrollment) | ELIGIBLE<br>FOR<br>MEDICARE |    | ELIGIBLE<br>FOR<br>CHAMPUS |    |
|-------------------------------|--|---------------------|--------------------------------------|---------------------------------|----------------------------|--|-----------------------------|----|----------------------------|----|
|                               |  |                     |                                      |                                 |                            |  | YES                         | NO | YES                        | NO |
|                               |  |                     |                                      |                                 |                            |  |                             |    |                            |    |
|                               |  |                     |                                      |                                 |                            |  |                             |    |                            |    |
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|  |                                    |      |
|--|------------------------------------|------|
| <b>I understand the questions. The answers to all questions are true and correct to the best of my knowledge and belief.</b> | SIGNATURE OF APPLICANT OR GUARDIAN | DATE |
|--|------------------------------------|------|

**PRIVACY ACT:** The information requested on this form is needed to determine your eligibility for medical benefits, and is requested under the authority of 38 U.S.C., Section 1713. Although your submission of this information is voluntary, no medical benefits may be provided until an application has been received and a subsequent eligibility determination made. This information may be disclosed outside VA (Department of Veterans Affairs) without your prior written consent as permitted by law, or as stated under the "Routine Uses" heading of the pertinent systems notice in the Privacy Act "Notices of Systems of VA Records". These "routine uses" include disclosures: in response to court subpoenas; to Federal agencies for the purpose of conducting government research; in connection with collections owed to the United States; to the Department of Justice for use in litigation; to other Federal agencies in connection with their employment determinations, investigations, or issuance of licenses or benefits; to report apparent law violations to other Federal, State, or local agencies charged with law enforcement responsibilities; or, to OCHAMPUS (Department of Defense, Office Of Civilian Health and Medical Programs of the Uniformed Services) and OCHAMPUS fiscal intermediaries, and DEERS (Defense Eligibility Enrollment Reporting System) to the extent necessary to determine eligibility for CHAMPVA or CHAMPUS benefits. Failure to furnish this information will have no adverse effect on any other benefits to which you may be entitled.

**PAPERWORK REDUCTION ACT INFORMATION:** Public reporting burden for this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to: VA Clearance Officer (045A4), 810 Vermont Avenue NW, Washington DC 20420, and to the Office of Information and Regulatory Affairs, Paperwork Reduction Project (2900-0219), Office of Management and Budget, Washington DC 20503. DO NOT send applications to this address.